STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155203	A. BUILDING 00 B. WING	01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST VILLAGE	203 SPARKS AVE JEFFERSONVILLE, IN 47130

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F0000	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00122444. Complaint IN00122444 - Unsubstantiated due to lack of sufficient evidence. Survey Dates: January 14, 15, 16, 17, and 18, 2013 Facility Number: 000110 Provider Number: 155203 AIM Number: 100271120 Survey Team: Gloria J. Reisert, MSW/TC Jill Ross RN (1/15, 1/16, 1/17, and 1/18/2013) Diana Sidell RN Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 17 Medicaid: 62 Other: 02	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for survey ending July 30, 2012. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allecgation of compliance. Thus, the facility respectfully requests the granting of paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 81 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on 1/28/2013, by Cheryl Fielden, RN			

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F0242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review, observation and interview the facility failed to ensure a resident had the right to choose when to get up in the morning. This affected 1 of 3 residents reviewed for choices. (Resident #30) Findings include: Review of the record of Resident #30 on 1/16/13 at 10:45 a.m., indicated diagnoses included, but were not limited to: congestive heart failure, high blood pressure, dementia, renal insufficiency, anemia, gastric reflux, chronic anxiety, history of stroke, history of heart attack, osteoarthritis, major depressive disorder, hyperlipidemia, and chronic kidney disease. During an interview on 1/16/13 at 9:06 a.m., with Resident #30 she indicated she did not get a choice as	F0242	What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: · Resident #30 was re-interviewed and preferences were revised on CNA assignment sheet. Resident # 1 is getting up later in the morning.How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken: · All residents have the potential to be affected by the alleged deficient practice. · The nursing staff will be re-educated by the Social Services/designee on or before 02/17/13 on Resident Rights with emphasis on honoring resident choices . . An audit will be conducted to ensure resident choices are honored. If changes in Resident preferences are identified, the CNA assignment will be revised.· The director of nursing services/designee is responsible to ensure compliance What measures will be put into place or what systemic changes you will make to ensure the	02/17/2013

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	to when she got up in the morning. "They get me up when they want me up. Last week they got me up at 4:00 a.m." An interview on 1/18/13 at 10:44 a.m., with CNA #1, indicated Resident #30 "does not like getting up early and never has even when she was downstairs". She also indicated that Resident #30 sometimes refuses to get up in the morning. She indicated this resident prefers to get up around 10:00 a.m. An interview on 1/18/13 at 10:48 a.m., with LPN #1 indicated Resident #30 had never stated a preference for getting up in the morning. If she did it would be on the CNA Sheet. Review of the CNA sheet indicated there was no preference as far as time to get up in the morning. "They should go in and ask her if she is ready to get up and if not let her rest until she is ready. They always have a choice." On 1/17/13 at 7:30 a.m., Resident #30 was observed to be sitting in her wheelchair watching TV. She indicated she was still tired and wished she was in bed. A policy titled "Resident Rights" was received from the Director of Nursing		deficient practice does not recur: · The nursing staff will be re-educated by the DNS/designee on or before 02/17/13 on Resident Rights with emphasis on honoring resident preferences. . The activity staff will conduct the Preferences for Daily Customary Routines form during the residents quarterly, annual and significant change assessments. These preferences are reviewed during the IDT meetings.· The Director of Nursing/designee is responsible to ensure compliance.How the corrective action(s) will be monitored to ensure the deficient practice will not recur: · The CQI audit tool for Resident Interviews will be utilized weekly x 4 weeks, monthly x 6 months. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.	

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	on 1/18/13 at 3:17 p.m. This policy indicated, "...This document informs each resident/responsible party of his/her rights and responsibilities regarding medical care while a resident at the facility...All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care..." A copy of a "Preferences for Daily Customary Routines" for Resident #30 and dated 10/25/12 was received from the Administrator on 1/18/13 at 5:15 p.m. This document indicated, "Do you have a preference as to what time you get up? "Yes" was marked and then crossed out and there was a check in the no box. 3.1-3(u)(1)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents residing on 1 of 3 halls had side rails openings no greater than 4.75 inches. This affected 2 of 4 residents residing in the facility that were reviewed for side rails with larger than allowed openings. (Residents #35 and 70) Findings include: During the initial tour on 1/14/13 at 10:55 a.m., Residents #70 and #35 were observed to have 2 half rails in the up position that had openings inside the rails larger than 4.75 inches. On 1/15/13 at 4:00 p.m., measurements were completed on the side rails for Residents #70 and #35. The side rails had 4 openings in each half rail, the first opening measured 5 1/2" by 7", the two middle openings measured 7" by 7 1/2", and the fourth opening measured 5 1/2"	F0323	F323 What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: · Resident #35 and # 70 side rail covers were immediately applied to the siderails.How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken: · All residents have the potential to be affected by the alleged deficient practice. · The nursing staff will be re-educated by the DNS/designee on or before 02/17/13 on ensuring side rail covers are applied to resident side rails.. An audit was conducted of all side rails and all residents with side rails with openiongs greater than 4.75 inches had side rail covers in place. · The director of nursing services/designee is responsible to ensure compliance What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: · The nursing staff will be re-educated by the DNS/designee on or before 02/17/13 on side rail covers. . · The Charge nurse is	02/17/2013

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	by 7 1/2". Resident #70's bed had 2 side rails at the head of the bed in the up position with these openings. Resident #35's bed had one side rail in the up position with these openings; the side rail that faced the door. Resident #35's second side rail was in the up position, but had a cover over the rail to enclose the openings. During an interview on 1/15/13 at 4:15 p.m., the Director of Nurses (DON) indicated the problem would be fixed before she left today. A policy and procedure for "Side Rail Assessment Procedure", dated 11/2010, was provided by the DON on 1/18/13 at 2:54 p.m. The policy indicated, but was not limited to, "...Side rails(s) use is needed by the resident to enable repositioning self in bed and/or transferring in and out of bed assisted or independently...." 3.1-45(a)(1)		responsible to check placement of side rail covers and document findings on the daily round checklist.· Non-compliance will result in further education including disciplinary action. · The Director of Nursing/designee is responsible to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: · The CQI audit tool for side rails will be utilized weekly x 4 weeks, monthly x 6 months. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.	

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F0332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on record review, observation and interview the facility failed to ensure they were free from medication error rate of greater than 5% in that the medication error rate was 9.09%. This affected 3 out of 10 residents observed during 4 medication passes. (Resident #5, Resident #30, and Resident #57). Findings include: During the medication pass observation on 1/17/13 at 7:45 a.m., with LPN #2, Resident #5 was due to have a Fentyl Patch placed at 8:00 a.m. LPN #2 did not have a patch available to place on Resident #5. She indicated she would notify the physician and the pharmacy to get it taken care of right away. The physician had changed the dose of the patch and LPN #2 indicated the new order had not been sent to pharmacy. She received an order to hold the patch until it arrived from the pharmacy. It had not arrived by 12:00 p.m., on 1/17/13.	F0332	**F332What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #5, Resident #57, and Resident #30** are recieving medications per physician orders and nursing standards of practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**. All residents have the potential to be affected by this practice.. Licensed nurses will be in-serviced on or before 02/17/13 by the SDC/designee on administering medications to include timeliness and availability.. Skills check offs will be completed for licensed nurses per the SDC/designee on medication administration on or before 02/17/13.. The DNS/designee will conduct a100% audit of medications to ensure all medications are available. . The DNS/designee will be responsible for compliance.**What measures will be put into place or what systemic changes will be made to ensure that the deficient**	02/17/2013

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	During the medication pass observation on 1/17/13 at 8:00 a.m., with LPN #2, Resident #57 did not have 3 of her daily medications available. She did not receive her Stalevo 75 mg for Parkinson's disease which was ordered for 2 times a day. Her Folic Acid 1 mg for anemia which she was ordered for everyday. Her Miralax 17 GMs for constipation which she was to have 2 times everyday. LPN #2 notified the doctor and the pharmacy. She received an order to hold the medications until they came from the pharmacy. The medications had not been ordered from pharmacy until she sent the order. They had not arrived to the facility by 12:00 p.m., on 1/17/13. During the medication pass on 1/17/13 at 8:15 a.m., with LPN #3, Resident #30 requested Tylenol for pain. There was none available in the medication cart for this resident or in the emergency drug kit. The medication had not been ordered from pharmacy. 1/17/13 at 10:12 a.m., with LPN #1, she indicated all nurses are responsible for pulling the stickers and reordering the medications. "Meds are not available some but not		**practice does not recur?** . Licensed nurses will be in-serviced on or before 02/17/13 by the SDC/designee on administering medications to include timliness and availability.. Skills check offs will be completed for licensed nurses on all shifts per the SDC/designee on medication administration on or before 02/17/13.. Medication cart/medication room audits will be conducted weekly to ensure medications are available, properly stored and expiration dates are within appropriate date ranges by DNS and/or designee.. Non compliance with these practices will result in further education includingdisciplinary action. The DNS is responsible for compliance.**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?. The CQI audit tool for pharmacy services will be completed weekly x4,monthly x 6 months. . Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practices below the 95% threshold.**	

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	a lot. Sometimes pharmacy is late getting them to us. If the medicine is not available there is a 4 hour window to get the medication so morning medications would be held until the next dose or as the physician ordered. The physician is notified when medications are not available and they give the nurses an order for what they want them to do." A policy titled, "Re-Order Medications" was received from the Director of Nursing on 1/18/13 at 12:43. This policy indicated, "Purpose: To ensure the resident(s) has/have a supply of ordered medications at all times. Procedure: The Nurse Will: Reorder medications 4 days before the current supply will be exhausted..." A policy to show what times medications were given when it was "every day" or "twice a day" was asked for, but was not provided by the facility. 3.1-25(b)(9)			

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F0425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review, observation and interview the facility failed to ensure medications were re-orded in a timely manner to ensure continuity of administration of medications in that 3 residents did not have medications available at the times they were to be administered. This affected 3 out of 10 residents observed during 4 medication pass observations. (Resident #5, Resident #30, and Resident #57) Findings include:	F0425	**F425 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #5, Resident #57, and Resident #30**are receiving medications per physician orders and nursing standards of practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? . All residents have the potential to be affected by the alleged deficient practice.** . Licensed nurses will be in-serviced on or	02/17/2013

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	During the medication pass observation on 1/17/13 at 7:45 a.m., with LPN #2, Resident #5 was due to have a Fentyl Patch placed at 8:00 a.m. LPN #2 did not have a patch available to place on Resident #5. She indicated she would notify the physician and the pharmacy to get it taken care of right away. The physician had changed the dose of the patch and LPN #2 indicated the new order had not been sent to the pharmacy. It had not arrived by 12:00 p.m., on 1/17/13. During the medication pass observation on 1/17/13 at 8:00 a.m., with LPN #2, Resident #57 did not have 3 of her daily medications available. She did not receive her Stalevo 75 mg for Parkinson's disease which was ordered for 2 times a day. Her Folic Acid 1 mg for anemia which she was ordered for everyday. Her Miralax 17 GMs for constipation which she was to have 2 times everyday. The physician and pharmacy were notified. She received an order to hold the medications until they came from the pharmacy. The medications had not been ordered from pharmacy until she sent the order. They had not arrived to the facility by 12:00 p.m., on 1/17/13.		before 02/17/13 by the SDC/designee on administering medications, timliness of ordering medications and medication availability. . Skills check offs will be completed for licensed nurses per the SDC/designee on medication administration on or before 02/17/13. . A 100% audit of medications will be conducted to ensure all medications are available. . The DNS/designee will be responsible for compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** . Licensed nurses will be in-serviced on or before 02/17/13 by the SDC/designee on administering medications to include timeliness and availability. . Skills check offs will be completed for licensed nurses on all shifts per the SDC/designee on medication administration on or before 02/17/13.. . The DNS is responsible for compliance. . Non compliance with these practices will result in further education including disciplinary action. **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? . The CQI audit tool for pharmacy services will be completed weekly x4, monthly**	

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	During the medication pass on 1/17/13 at 8:15 a.m., with LPN #3, Resident #30 requested Tylenol for pain. There was none available in the medication cart for this resident or in the emergency drug kit. The physician and pharmacy were notified. The medication had not been ordered from the pharmacy. 1/17/13 at 10:12 a.m., with LPN #1, she indicated all nurses are responsible for pulling the stickers and reordering the medications. "Meds are not available some but not a lot. Sometimes pharmacy is late getting them to us. If the medicine is not available there is a 4 hour window to get the medication so morning medications would be held until the next dose or as the physician ordered. The physician is notified when medications are not available and they give the nurses an order for what they want them to do." A policy titled, "Re-Order Medications" was received from the Director of Nursing on 1/18/13 at 12:43. This policy indicated, "Purpose: To ensure the resident(s) has/have a supply of ordered medications at all times. Procedure: The Nurse Will: Reorder medications 4 days before the current supply will		**x 6 months. .** Skills check offs will be completed for licensed nurses on all shifts per the SDC/designee on medication administration on or before 02/09/13. **. Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practices below the 95% threshold.**	

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	be exhausted..." A policy to show what times medications were given when ordered "everyday" or "twice a day" was asked for but not provided by the facility. 3.1-25(g)(3)			

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	155203	A. BUILDING 00 B. WING	01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST VILLAGE	203 SPARKS AVE JEFFERSONVILLE, IN 47130

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F0431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on record review, observation and interview the facility failed to ensure all medications in the facility	F0431	**F431 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?. Resident # 1**	02/17/2013

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	were properly labeled with resident's name and instructions as to how and when medications were to be given and that there were no expired medications in the medication rooms or med carts. This affected one resident and had the potential to affect all 81 residents residing in the facility. (Resident #1) Findings include: On 1/18/13 at 11:45 a.m., medication storage was checked with the Director of Nursing. The medication cart on the south unit had a clear plastic bag of Ipratropium Bromide 0.5% with no identification as to resident they were for or the instructions for administration. There were 50 vials in this bag. There was one bottle of MOM for Resident #1 which was expired on 11/12. On 1/18/13 at 12:20 p.m., in the TCU med cart there was Betamethasone cream in the cart without a name or instructions. There was Santyl cream which was opened with no name or instructions on it. Two bottles of Calcium 600-D were expired 6/12 and had no name on them or instructions for administration. Siltussin 4 oz bottle with no name or instructions. Vitamin B-12 with the last name of a		**medication was reordered and expired medications were appropriately removed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?. All residents have the potential to be affected by the alleged deficient practice.. A 100% audit of all medications will be completed to ensure all labels are legible. During the audit a review expiration dates will be conducted to ensure no expired medications are present. The audit will be conducted by the DNS. What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur.. The nursing staff will be re-educated by the SDC/designee on or before 02/17/13 on pharmacy policy on proper storage and labeling of medications..** Medication cart/medication room audits will be conducted weekly to ensure medications are available, properly stored and expiration dates are within appropriate date ranges by DNS and/or designee.. **Non-compliance will result in further education including disciplinary action. · The Director of Nursing/designee is responsible to ensure**	

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	resident written on it (there are 2 residents with that last name) and no instructions. On 1/18/13 at 12:00 p.m., an interview with the Director of Nursing indicated the nurses are responsible for checking all items to be sure they are labeled and dated correctly. They also should be checking for expiration dates. A policy titled, "Labeling of Medications" was received for the Director of Nursing on 1/18/13 at 3:17 p.m. This policy indicated, "...Procedure: All Medications with a prescribers order: Labeling for all medications must be: Typed or printed and clearly indicate: Resident/patient full name Prescription number Name and strength of the drug Route and time (s) the medication is to be given (if indicated on the prescription order) Quantity of drug/medication dispensed Date dispensed Expiration date of all time dated drugs		**compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: · The CQI audit tool for Pharmacy Services will be utilized weekly x 4 weeks, monthly x 6 months by the DNS and/or designee. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.**	

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	Prescriber's name The name, address, and telephone number of the dispensing pharmacy. Any other pertinent information as may be needed or required..." 3.1-25(j)(k)			

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on record review, interview	F0441	**F441What corrective action(s) will be accomplished for those**	02/17/2013

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	and observation the facility failed to ensure proper glove use for in that gloves were used for multiple things and then for IV administration. This affected 1 of 1 residents reviewed for IV administration. (Resident #122) Findings include: On 1/17/13 at 11:45 a.m., LPN #3 went into Resident #122's room to change out the IV fluids. The bag hanging was almost empty and she had a new one to hang. LPN #3 hung the bag of fluid on the IV pole and washed her hands. She put gloves on and then rolled the head of the bed down, repositioned and covered the resident. With the same gloves she then went over and changed out the IV bags. An Interview with LPN #3 on 1/17/13 at 11:55 a.m., she indicated she should have changed her gloves after working with the resident before working with the IV. A policy titled, "IV Medication Administration" was received from the Director of Nursing on 1/18/13 at 12:43 p.m. This policy indicated, "...6. Wash hands and put on gloves. 7. Connect all equipment..."		**residents found to have been affected by the deficient practice?**Resident #122 is recieving the appropriate care based on the infection control policies and practices. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?. All residents have the potential to be affected by the alleged deficient practice.** . Nursing Staff will be re-educated on hand washing, use of gloves policy and procedures by the SDC/designee on or before 02/17/13 with post test included.. Skills checks will be completed for nursing staff by the SDC/designee on or before 02/17/13. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** . The nursing staff will be re-educated on hand washing, use of gloves policy and infection control policy and procedures by the SDC/designee on or before 02/17/13 with post test included.. Skills checks will be completed for nursing staff by the SDC/designee on handwashing and glove usage on/or before 02/17/13.. SDC and/or designee will observe handwashing technique and monitor infection control practices as it relates to handwashing and glove use 5 x	

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	3.1-18(a)		per week and include all three shifts and weekends.. The DNS/designee will be reponsible to ensure compliance.. Non-compliance with these practices will result in further education including disciplinary action.How the corrective action(s) will be monitored to ensure the deficient practice will not recur: · The CQI audit tool for Infection Control will be utilized weekly x 4 weeks, monthly x 6 months by the DNS and/ or Designee. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.	